Chapter 56 reserved

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 57

MATERNAL AND CHILD HEALTH

Subchapter 1

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Subchapter 1

Handicapped Children's Services Program

37.57.101 PURPOSE OF RULES (1) The purpose of the children's special health services program rules is to provide health care services for children with special health care needs. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; TRANS, from DHES, 2001 MAR p. 398.)

37.57.102 DEFINITIONS Unless otherwise indicated, the following definitions apply throughout this subchapter:

(1) "Advisory committee" means a committee that is composed of health care service providers, public health providers, consumers, and children's special health service (CSHS) program staff and that advises the department about CSHS program operation.

(2) "Applicant" means a child or youth who has applied or whose parent or guardian has applied on the child's behalf to receive CSHS benefits from the department.

(3) "Benefits" means payment by the department for CSHS-authorized medical care for a child or youth eligible for the CSHS program.

(4) "Child or youth" means an individual under 22 years of age.

(5) "CHIP" means the Montana children's health insurance plan administered by the department.

(6) "Client" means a child or youth who is eligible to receive CSHS benefits as determined by the department under this subchapter.

(7) "Clinic" means a place where a team of health care providers with specialties appropriate to treating children come together to evaluate and develop a comprehensive plan of care for children with specific disabilities.

(8) "CSHS" means the children's special health services program of the department, authorized by 50-1-202, MCA, that serves children with special health care needs.

(9) "CSHCN" means children with special health care needs, the population served by CSHS.

(10) "Department" means the Montana department of public health and human services.

(11) "Disability" or "disabling condition" means a chronic physical, developmental, behavioral or emotional condition requiring health and related services of a type or amount beyond that required by children generally.

(12) "Disabled" means having any physical defect or characteristic, congenital or acquired, that prevents or restricts normal growth or capacity for activity.

(13) "Eligibility year" means the year in which a child or youth receives CSHS benefits, beginning with the date the application for those benefits is received by the department and ending 12 months later.

(14) "Evaluation" means the medical examination and testing needed to determine the cause and possible treatment for a suspected or known disability.

(15) "Family" means a group of related or non-related individuals who are living together as a single economic unit.

(16) "Federal fiscal year" means the period beginning October 1 and ending the following September 30.

(17) "ICD-9-CM" means the World Health Organization's International Classification of Diseases, Clinical Modification, 9th Revision.

(18) "Initial diagnosis and evaluation" means taking a medical history and performing a physical examination, medical procedures, laboratory tests, hearing tests, or other procedures necessary for the diagnosis of a condition for the purpose of establishing CSHS eligibility.

(19) "Medical advisor" means a physician with expertise in treating children with special health care needs and licensed by the state of Montana who serves as an advisor to the department.

(20) "Poverty income guidelines" means the poverty income guidelines published in 2003 in the Federal Register by the U.S. department of health and human services. The department hereby adopts and incorporates by reference the federal poverty guidelines that establish income thresholds according to family unit size for purposes of determining eligibility for government assistance or services and that are published in the February 7, 2003, Federal Register. A copy of the 2003 poverty guidelines may be obtained from the Department of Public Health and Human Services, Child and Adult Health Resources Division, Children's Special Health Services Program, 1218 East Sixth, Helena, MT 59620, telephone (406)444-3617.

(21) "Program" means the department's children's special health services program for children with special health care needs, authorized by 50-1-202, MCA.

(22) "Provider" means a supplier of medical care or services, medical appliances, prescribed medications, or formula or foods.

(23) "Services" means assistance other than benefits provided to CSHCN, such as resource and referral information, transition information, specialty clinic services, and care coordination.

(24) "Third party" means a public or private agency that is or may be liable to pay all or part of the medical costs for a client, including, but not limited to, private insurance, tri-care, medicaid, medicare, CHIP, the caring program for children, and the early intervention program, part C, of the department's disabilities services division.

(25) "Treatment" means medical, corrective, and/or surgical intervention to alleviate a disabling condition. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

Rules 03 and 04 reserved

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37.57.105 GENERAL REQUIREMENTS FOR CSHS ASSISTANCE

(1) In order to receive CSHS financial assistance for a particular benefit:

(a) child or youth must meet the eligibility requirements of ARM 37.57.106; and

(b) have an eligible condition that is listed in ARM 37.57.110;

(c) the benefit in question must be one of the covered benefits cited in ARM 37.57.110, and the provider must meet the standards of ARM 37.57.117. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

37.57.106 ELIGIBILITY FOR BENEFITS (1) With the exception noted in (6), a child or youth, to be eligible for CSHS benefits, must be:

(a) a child or youth with either a disabling physical condition that can be substantially improved or corrected with surgery, or a condition or disease that can be cured, improved, or stabilized with medical treatment, or a child or youth suspected of having a disabling physical condition or a medical condition or disease;

(b) under 19 years of age or under 22 years of age if the child or youth has a disability for which a final cleft surgery or dental work is necessary;

(c) a resident of the state of Montana and either a U.S. citizen or a qualified alien as defined under federal statute;

(d) a member of a family whose income, less any out-of-pocket expenses for health insurance, is at or less than 200% of the federal poverty income guidelines; and

(e) one of the following:

(i) ineligible for medicaid;

(ii) eligible for medicaid, but in need of services or benefits that are not covered by medicaid but are covered by CSHS; or

(iii) potentially eligible for medicaid from information provided on the application, the family will be referred to the county office of public assistance for medicaid eligibility determination.

(2) Eligibility for program benefits will be determined within 30 days of receipt of the application by the department.

(3) Eligibility continues for 12 months from the date an application is received unless the child's or youth's age precludes them from participation or the child or youth moves from Montana.

(4) A new or renewal application for a subsequent year must be submitted to the department in order for the department to determine if eligibility is to continue and must be completed and approved before any CSHS benefits in a subsequent year may be provided.

(5) CSHS financial eligibility will be determined in accordance with the financial eligibility guidelines contained in CHIP's ARM 37.79.201, with the following exceptions:

(a) children who are eligible to receive state employee health coverage may be eligible for CSHS benefits;

(b) children may have health insurance coverage and the out-of-pocket expenses for health insurance are deducted from household income; and

(c) CSHS financial eligibility is at or below 200% of the federal poverty income guidelines.

(6) The above financial eligibility limits do not apply to a child or youth who has or is suspected of having a condition covered by CSHS and wishes to attend a clinic specifically for that condition. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1991 MAR p. 1723, Eff. 9/13/91; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 1993 MAR p. 1933, Eff. 8/13/93; AMD, 1994 MAR p. 1836, Eff. 7/8/94; AMD, 1995 MAR p. 1804, Eff. 9/15/95; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

Rules 07 and 08 reserved

37.57.109 APPLICATION PROCEDURE (1) A person who desires CSHS benefits for a child or youth must submit a completed application, along with supporting documents required by the department, to the department on a form it prescribes.

(2) If the department notifies the applicant that the application is incomplete and is not provided with the requested information within six weeks after the date the applicant was notified of the deficiency, the application will be considered inactive. If the requested information is subsequently received and the child or youth is found to be eligible, the eligibility year will begin on the date the additional requested information is received.

(3) If the child or youth is found not eligible, the department will send the applicant a notice stating the reasons for ineligibility and explaining how an informal reconsideration of its determination may be obtained pursuant to ARM 37.57.112.

(4) If the applicant is determined eligible, the department will send the applicant a notice of that fact specifying which conditions are eligible for CSHS assistance. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 2000 MAR p. 1653, Eff. 6/30/00; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

37.57.110 CONDITIONS, BENEFITS AND SERVICES (1) To the extent department funding allows, and up to a maximum of $12,000 per eligibility year, the department will provide benefits as cited in (3) for the eligible conditions listed in (2), subject to the exceptions to benefits and conditions in (4) and (5).

(2) Eligible conditions are:

(a) genitourinary disorders;

(b) gastrointestinal disorders;

(c) metabolic disorders;

(d) neurological disorders;

(e) orthopedic disorders;

(f) craniofacial anomalies, including cleft lip and cleft palate;

(g) ophthalmic conditions;

(h) pulmonary disorders;

(i) endocrine disorders;

(j) juvenile rheumatoid arthritis, or similar arthritic disorders;

(k) cardiovascular disorders;

(l) chronic infectious disease;

(m) hematologic disorders; and

(n) dermatologic disorders.

(3) The following are covered benefits that may be provided to a CSHS eligible child or youth:

(a) evaluation, diagnosis and treatment, including surgical correction;

(b) evaluation and outcome management of developmental delay by a developmental pediatrician;

(c) appliances required for correction of a covered condition;

(d) medical foods for the treatment of a metabolic disorder, including prescriptive supplements for a child with inborn errors of metabolism;

(e) prosthetic devices, such as orthotics for a covered orthopedic condition;

(f) occupational, physical, nutrition and speech therapy for rehabilitation related to a covered service;

(g) allergy injections on the recommendation of a pediatric allergist after other preventive measures have been exhausted;

(h) hearing aids, up to a maximum of $1,500 per ear per year;

(i) one dental visit per eligibility year;

(j) one well child visit per eligibility year;

(k) breast pump purchase or rental (up to one year) to aid the mother of a newborn with a covered condition;

(l) eyeglasses for a child with a medical disorder-related condition, limited to a single pair of frames per eligibility year up to a maximum of $175 for frames, lenses and evaluation, plus an additional prescription lens change in six months as needed;

(m) disposable medical equipment for covered conditions;

(n) apnea monitor rental for a covered condition (up to one year);

(o) case management and care coordination;

(p) tonsillectomy and adenoidectomy in cases of obstructive sleep apnea or to protect hearing; and

(q) prescription medications related to the covered condition.

(4) No benefits are available for the following:

(a) acute care for illness or injury;

(b) insulin pumps;

(c) visual training therapy;

(d) home health and home nursing services for acute cases;

(e) legal services;

(f) psychological and psychiatric care and counseling;

(g) respite care;

(h) wheelchairs;

(i) transplants, including follow up care;

(j) transportation;

(k) growth hormone therapy, except for medically established hypothalamic/pituitary insufficiency;

(l) services provided outside of Montana, unless the required service is not available in-state or, due to the vast distances within Montana, the requirement to obtain in-state services places an undue hardship on a family;

(m) appliances, with the exception of orthopedic braces, prosthetic devices and appliances required for the correction of an orthodontic condition that affects an otherwise CSHS covered condition, such as that caused by the presence of a cleft palate or another syndrome-caused craniofacial anomaly;

(n) speech, occupational, nutritional, physical or respiratory therapy for a condition that is not CSHS-eligible;

(o) treatment for cleft/craniofacial conditions that are not planned and recommended by a multi-disciplinary cleft/ craniofacial team that meets American cleft palate-craniofacial association parameters.

(5) Conditions that are ineligible for financial assistance are:

(a) conditions which are usually non-remediable with no potential for long-term habilitation;

(b) behavioral, emotional, and learning disabilities;

(c) primary psychiatric diseases;

(d) injuries and illnesses; and

(e) catastrophic diseases, including neoplasms and other cancers.

(6) Standards for services that may be provided by CSHS are the following:

(a) to the extent CSHS funding allows and up to a maximum of $5,000 per person per federal fiscal year, the following services may be provided by the department to persons diagnosed with a CSHS-covered condition:

(i) resource and referral information;

(ii) transition information; and

(iii) nutritional counseling and management, medical formula or foods, and/or prescriptive medications not funded by other sources for a person identified with an inborn error of metabolism.

(b) services provided may not be covered by another payment source; and

(c) a person receiving services must:

(i) be a Montana resident; and

(ii) live in a household that meets CSHS income standards for benefit eligibility. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 1994 MAR p. 1836, Eff. 7/8/94; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

37.57.111 PAYMENT LIMITS AND REQUIREMENTS (1) The department will provide benefits for a CSHS-eligible child or youth with a covered condition:

(a) if the benefit is not covered by another payment source, with the exception of the Indian health service (IHS), which is a payer of last resort;

(b) if the department has sufficient federal funds to provide the benefit;

(c) up to a maximum of $12,000 per eligibility year;

(d) up to a maximum of $1,500 each for speech, physical, nutritional, occupational, or respiratory therapy related to a covered condition. For children under age three, CSHS will pay after the early intervention program, part C, of the disabilities services division; and

(e) after all third parties, if any, have paid the provider, in which case the department pays any balance remaining for services not covered by another payment source, within CSHS limits for the services in question.

(2) The department will pay providers directly for CSHS-eligible care and will not reimburse clients.

(3) The department will pay eligible providers after the department receives a signed authorization form and documentation that the care has been provided.

(4) A provider, family, or individual who erroneously or improperly is paid by the department must promptly refund that payment to the department.

(5) A provider who accepts the CSHS level of payment for covered benefits may not seek additional payment from a CSHS client or their family.

(6) The department will pay up to the following limits for orthodontia care:

(a) Payment for orthodontia for CSHS clients who have cleft or craniofacial conditions requiring orthodontia due to a medical condition with orthodontic implications will be subject to the maximum allowable charge published in the department's orthodontic coverage and reimbursement guidelines updated through July, 2001.

(b) Payment will be based on a treatment plan submitted by the provider that meets the requirements of the department's orthodontic coverage and reimbursement guidelines and that includes, at a minimum, a description of the plan of treatment, the provider's estimated usual and customary charge, and a time line for treatment. The department will reimburse 40% of the CSHS allowed amount upon initial billing for each phase of treatment, the remainder being paid in monthly installments as determined by the time line established in the provider's treatment plan for completing orthodontic care.

(c) A client is limited to:

(i) an overall lifetime cap of $7,000 for all orthodontia phases; and

(ii) the maximum for each phase cited in the department's orthodontic coverage and reimbursement guidelines updated through December 1999.

(d) Maximum allowable charges for each phase of orthodontic treatment, time lines for orthodontic phases of care, and the services included in each phase of orthodontic care are listed in the department's orthodontic coverage and reimbursement guidelines. The department hereby adopts and incorporates by reference the department's orthodontic coverage and reimbursement guidelines updated through July, 2001. The guidelines, issued by the department to all providers of orthodontic services, inform providers of the requirements applicable to the delivery of services under the medicaid program. A copy of the department's orthodontic coverage and reimbursement guidelines is available from the Department of Public Health and Human Services, Child and Adult Health Resources Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(7) For services to a CSHS client, with the exception of multiple surgeries, a provider will be paid 85% of the actual submitted charge for the approved services.

(8) For multiple surgeries, the department will pay at the following rates:

(a) 85% of the actual charge for multiple surgeries performed during the same admission, but on different days.

(b) for multiple surgeries performed on the same day, under the same anesthesia:

(i) involving a single surgical field or single surgical incision, regardless of how many organ systems are involved, performed by one or two surgeons:

(A) 85% of the actual charge for the first procedure; and

(B) 75% of the actual charge for the second procedure;

(ii) involving two surgical fields or two surgical incisions performed by one surgeon, whether the surgery involves separate organ systems, different anatomical locations, or bilateral surgical procedures:

(A) 85% of the actual charge for the first procedure; and

(B) 75% of the actual charge for the second and each subsequent procedure.

(iii) involving two surgical fields or two surgical incisions performed by two surgeons, whether the surgery involves separate organ systems, different anatomical locations, or bilateral surgical procedures, 85% of the actual charge for the first and second procedures.

(iv) involving bilateral surgical procedures (e.g. bilateral Colles' fracture):

(A) 85% for the first procedure; and

(B) 75% for the second procedure.

(9) Hospitals and surgicenters will be paid 85% of the actual submitted charge on the date of occurrence for inpatient and outpatient services.

(10) Dentists will be paid 85% of billed charges for an annual dental exam and dental extractions related to active or anticipated orthodontia treatment.

(11) In addition to the above, the department will pay:

(a) the lesser of either the actual charge for drugs and other prescribed supplies, or the price cited in the 2002 Drug Topics Redbook Pharmacy's Fundamental Reference, less 15%, plus a $4.70 dispensing fee and any minor adjustments deemed reasonable by the department to reflect market changes;

(b) 85% of the cost of orthotics and prosthetic devices (orthopedic only);

(c) 100% of the cost of specialized formula and foods and prescriptive or non-prescriptive medications prescribed by a physician for inborn errors of metabolism;

(d) 100% of the cost of syringes and disposable medical equipment for the treatment of covered conditions; and

(e) rental or purchase of durable medical equipment authorized by CSHS professional staff.

(12) Clinic services provided at a clinic funded or supported by the department are provided free of charge, regardless of the client's household income.

(13) The department hereby adopts and incorporates by reference the 2002 Drug Topics Redbook Pharmacy's Fundamental Reference, which suggests prices for drugs. Anyone wishing to examine any of the above references may do so by contacting the department's CSHS program at Department of Public Health and Human Services, Child and Adult Health Resources Division, Children's Special Health Services Program, 1218 East Sixth Avenue, Helena, MT 59601, phone: 444-3617. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 1994 MAR p. 1836, Eff. 7/8/94; AMD, 1999 MAR p. 2879, Eff. 12/17/99; TRANS, from DHES, 2001 MAR, p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

37.57.112 INFORMAL RECONSIDERATION PROCEDURE (1) A child or youth who has been denied eligibility for CSHS, a provider who has been denied reimbursement for services or covered benefits, or anyone who is otherwise adversely affected by an action taken by the department may have an informal reconsideration before the department by requesting such a reconsideration within 60 days after notice of the adverse action in question has been placed in the mail or otherwise communicated to the aggrieved party.

(2) A request for a reconsideration, in order to be considered, must be in writing, include refutation of the department's findings, and be postmarked no later than the 60th day after notice of the adverse action referred to in (1) was given.

(3) If the department receives a request for an informal reconsideration, it will conduct the reconsideration within 30 days after the date the request is received unless both the requestor and the department agree to a later date.

(4) An informal reconsideration will be conducted in accordance with the procedures prescribed for informal reconsideration in ARM 37.5.311, with the exceptions noted in (1) and (5). Such informal reconsideration is not subject to the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA, or, except as provided in this rule, the provisions of ARM 37.5.304, 37.5.307, 37.5.310, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(5) In addition to the procedures specified in ARM 37.5.311, an applicant shall be provided an opportunity to appear and present evidence and arguments in person.

(6) The decision by the department after an informal reconsideration is final. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 2000 MAR p. 1653, Eff. 6/30/00; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

Rules 13 through 16 reserved

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37.57.117 CSHS PROVIDER REQUIREMENTS (1) In order to be a CSHS provider for a CSHS client, a provider must meet the following requirements:

(a) A physician or surgeon must:

(i) be currently licensed by the state of Montana pursuant to Title 37, chapter 3, MCA, to practice medicine as defined by state law if a Montana resident, or currently licensed to practice medicine in the state in which they reside;

(ii) be board-eligible or board-certified in the specialty for the condition being treated, or working in cooperation with a physician who is, unless the provider submits a curriculum vitae to the department and the CSHS medical advisor approves the provider as a specialty provider;

(iii) provide the department, upon request, with adequate documentation of credentials needed to prove program eligibility.

(b) An orthodontist must:

(i) be currently licensed as a dentist in the state of Montana or the state of residence;

(ii) have completed two years of graduate or post-graduate orthodontic training recognized by the council of dental education of the American dental association or the American orthodontic association; and

(iii) limit their practice to the area of orthodontics.

(c) A pediatric dentist may treat a child or youth under the age of 10 for orthodontia and must:

(i) be currently licensed as a dentist by the state of Montana or the state of residence; and

(ii) have completed a minimum of two academic years of a graduate or post-graduate pediatric dentistry program accredited by the council on dental accreditation of the American dental association.

(d) A hospital must be accredited by the joint commission of accreditation of healthcare organizations and be currently licensed and certified by the department, if in-state, or by the state in which it is located, if out-of-state.

(e) Any provider other than those listed in (1)(a) through (1)(d) must:

(i) be certified and/or licensed by the appropriate Montana authority, or if Montana has no certification or licensure requirements for the provider, be certified by a nationally recognized professional organization in the provider's area of expertise; and

(ii) shall provide services as ordered or prescribed by the attending physician.

(2) A provider must immediately supply the department with requested reports in order to permit effective evaluation of claims. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

37.57.118 PROGRAM RECORDS (1) The department shall retain records of CSHS services provided for a client for a period of five years after the child reaches the age of 18.

(2) Prior to destroying records, the department shall advertise that the records may be obtained by those to whom they pertain by publishing a notice in Montana's major newspapers once per week for three consecutive weeks.

(3) Records remaining unclaimed for three months after the public notice described in (2) is completed will be destroyed after the department receives the approval of the state records committee required by 2-6-212, MCA. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1637, Eff. 8/1/03.)

Rules 19 through 24 reserved

37.57.125 ADVISORY COMMITTEE (REPEALED) (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1990 MAR p. 1256, Eff. 6/29/90; AMD, 1992 MAR p. 919, Eff. 5/1/92; AMD, 1994 MAR p. 1836, Eff. 7/8/94; TRANS, from DHES, 2001 MAR p. 398; REP, 2003 MAR p. 1637, Eff. 8/1/03.)

Subchapter 2 reserved

Subchapter 3

Infant Screening Tests and Eye Treatment

37.57.301 DEFINITIONS (1) A newborn is an infant under 28 days of life.

(2) "Tests for inborn errors of metabolism" include laboratory tests for phenylketonuria, galactosemia, congenital hypothyroidism and hemoglobinopathies. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

Rules 02 and 03 reserved

37.57.304 VERY LOW BIRTH WEIGHT (UNDER 1,500 GRAMS) INFANTS: IN-HOSPITAL (1) If a newborn is of very low birth weight, i.e., under 1,500 grams, a sample of its blood must be taken for testing after 24 hours of age and no later than seven days of age, unless medically contraindicated, in which case the sample must be taken as soon as the infant's medical condition permits.

(2) If the infant is not yet feeding when the initial screening sample is collected, a repeat specimen for phenylalanine testing must be taken at least 48 hours following the first ingestion of milk.

(3) In the event that the infant stays in the hospital longer than 14 days, a repeat congenital hypothyroid screening must be made either at the time of the hospital discharge, if the hospital stay is a month or less, or at one month of age if the hospital stay is longer than one month. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

37.57.305 INFANTS OTHER THAN THOSE WITH VERY LOW BIRTH WEIGHT: IN HOSPITAL (1) The hospital or institution wherein newborn care was rendered to a newborn weighing 1,500 grams or more must take the required specimen:

(a) between 24 and 72 hours of age of each newborn; or

(b) 48 hours following its first ingestion of milk, but not later than the seventh day of life.

(2) In the event the newborn is discharged from the facility prior to the third day of life, the blood specimen must be taken immediately before discharge and, in addition, if the newborn is discharged before it is 24 hours old:

(a) another specimen must be taken and submitted to the department's laboratory between the fourth and 14th day of the newborn's life; and

(b) the administrative officer or other person in charge of the hospital or institution caring for newborn infants must:

(i) explain the reasons why it is of utmost importance to return for these tests; and

(ii) ensure that the parent or legal guardian of the newborn signs a statement assuming responsibility to cause a specimen to again be taken between the fourth and 14th day of life of the newborn and to submit it to the department for testing.

(3) If taking a specimen on any of the dates cited in (1) and (2) of this rule is medically contraindicated, the specimen must be taken as soon as possible thereafter as the medical condition of the infant permits. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1537, Eff. 7/1/03.)

37.57.306 TRANSFER OF NEWBORN INFANT (1) In the event of transfer of a newborn infant to another hospital or other institution, the specimen must be taken and submitted by:

(a) the transferring hospital or other institution if transfer occurs on or after the third day of life; or

(b) the receiving hospital or other institution if the transfer occurs before the third day of life.

(2) A hospital or other institution which receives a newborn who has not been previously tested must take a specimen for testing and submit it to the department's laboratory between the fourth and seventh day of the newborn's life, unless taking a specimen is medically contraindicated, in which case the specimen must be taken as soon as the medical condition of the infant permits. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

37.57.307 INFANT BORN OUTSIDE HOSPITAL OR INSTITUTION (1) When an infant has been born outside of a hospital or other institution and has not subsequently been admitted to such a facility for initial newborn care, it is the duty of the person required in 50-15-201, MCA, to register the birth of that child to cause the blood specimen to be taken not later than the seventh day of the child's life, unless medically contraindicated, in which case it shall be taken as soon as the medical condition of the infant permits. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

37.57.308 NEWBORN EYE TREATMENT (1) A physician, nurse-midwife, or any other person who assists at the birth of any infant must, within the time limit stated in (3) below, instill or have instilled into each conjunctival sac of the newborn one of the following:

(a) erythromycin (0.5%) ophthalmic ointment or drops from single-use tubes or ampules;

(b) tetracycline (1%) ophthalmic ointment or drops from single-use tubes or ampules; or

(c) silver nitrate solution (1%) in single-dose ampules.

(2) A prophylactic agent referred to in (1) above may not be flushed from a newborn's eyes after instillation.

(3) The prophylactic agent must be administered to a newborn within one hour after its birth unless it is physically impossible to obtain the agent within that time, in which case the agent must be administered as soon as possible. (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1987 MAR p. 2147, Eff. 11/28/87; TRANS, from DHES, 2001 MAR p. 398.)

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37.57.315 TRANSFUSION: WHEN SPECIMEN TAKEN (1) If a newborn needs a transfusion, blood specimens for the tests required by this subchapter must be taken before the transfusion takes place. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; NEW, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

37.57.316 ABNORMAL TEST RESULT (1) If an initial test result on an infant's blood specimen is outside the expected or normal range:

(a) the department will report that fact within 24 hours of test completion to the attending physician or midwife, or, if there is none or the physician or midwife is unknown, to the person who registered the infant's birth;

(b) the individual to whom the above report is made must ensure that a second blood specimen is taken within 24 hours of notification and submitted to the department for a second test.

(2) If the second test result is outside the expected or normal range:

(a) the department will provide the test results within 24 hours of test completion to the same person to whom the initial results were reported;

(b) that person must ensure that a serum specimen from the infant is immediately sent either to the department or to another approved laboratory qualified to perform quantitative analysis for the substance in question;

(c) if the specimen is sent to a laboratory other than the department's, the person who submits it must send the department a copy of the analysis report for the specimen within 24 hours after receiving the report.

(3) An approved laboratory includes any state or territorial health department laboratory and any laboratory within their jurisdictions which is approved by them, a U.S. public health service laboratory, a laboratory operated by the U.S. armed forces or veteran's administration, a Canadian provincial public health laboratory, and any laboratory licensed under the provisions of the Clinical Laboratories Improvement Act of 1967, as amended. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

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37.57.320 RESPONSIBILITIES OF REGISTRAR OF BIRTH: ADMINISTRATOR OF HOSPITAL (1) Each person in charge of any facility in which a newborn is cared for must:

(a) Ensure that a blood specimen is taken from each infant cared for by the facility, on the schedule noted in the rules in this subchapter, for the purpose of performing tests for inborn errors of metabolism.

(b) Be certain, prior to the discharge of the infant, that the specimen to be forwarded to the laboratory is adequate for testing purposes.

(c) Within 24 hours after the taking of the specimen, cause such specimen to be forwarded to the department's laboratory by first class mail or its equivalent.

(d) Record on the infant's chart the date of taking of the test specimen and the results of the tests performed when reported by the department.

(2) Each person who is responsible, pursuant to 50-15-201, MCA, for registering the birth of a newborn must ensure that:

(a) A blood specimen is taken from the infant for which that person is responsible, on the schedule noted in the rules in this subchapter.

(b) Ensure that the specimen is adequate for testing for inborn errors of metabolism.

(c) Ensure that the specimen is forwarded to the department's laboratory, by first class mail or its equivalent, within 24 hours after the specimen is taken.

(d) Record on the newborn's chart, if any, the date the test specimen was taken and the results of the tests performed when reported by the department. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398.)

37.57.321 STATE LABORATORY: RESPONSIBILITY FOR TESTS (1) Only those laboratory tests for inborn errors of metabolism which are performed by the department laboratory or, in the case described in ARM 37.57.316, a laboratory approved by the department, meet the requirements of 50-19-201, 50-19-202, 50-19-203 and 50-19-204, MCA. (History: Sec. 50-19-202, MCA; IMP, Sec. 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03.)

Subchapters 4 through 9 reserved

Subchapter 10

Block Grant Funds

37.57.1001 MATERNAL AND CHILD HEALTH BLOCK GRANT: STANDARDS FOR RECEIPT OF FUNDS (1) In order for any county or other local entity to receive federal maternal and child health (MCH) block grant funding from the department, that entity must contractually agree to the following:

(a) MCH block grant funds will be used solely for providing health services to mothers and children.

(b) No MCH block grant funds will be used to supplant local funds that would be otherwise available.

(c) MCH block grant funds will be used solely for the core maternal and child health services listed in (2) below, unless the contractor has proved to the department prior to entering into the contract that all core services have already been provided for or, through a formal needs assessment process meeting the requirements of (3) below, that the contractor has shown there is no need for the particular core service not being provided. If there is such an exception made to provision of all of the core services, the exception must be specifically set out in the contract.

(d) For every $4 of MCH block grant funding it spends, it must expend $3.00 from other non-federal funding sources to provide the services required of it by the contract.

(e) If the contractor has a medicaid billing mechanism in place, it will bill medicaid for services provided under the contract that qualify for medicaid reimbursement; and if a medicaid billing mechanism is not in place, the contractor will work with department staff to establish such a mechanism or to determine the feasibility of medicaid billing by the contractor, and will utilize the mechanism once it is established.

(f) No more than 10% of the funds available under the contract may be used for administration of the contract, i.e., for services that do not directly contribute to the delivery of direct services to clients; examples of administrative costs are those for bookkeeping, legal aid, and supervision by persons who are not health professionals.

(g) If the contractor conducted maternal and child health programs during the state fiscal year prior to that in which the contract is to be performed, the contractor must maintain during the term of the contract at least the same level of effort as it provided for those programs during prior fiscal year.

(h) Any grant-related income (for example, income from fees charged or donations) accruing to the contractor from activities funded, in whole or in part, under the contract will be used only to pay for the allowable costs of providing the services described in the contract, during the term of the contract or within one year thereafter. Careful documentation
of the use of grant-related income must be maintained.

(2) Core maternal and child health services are the following, when provided to pregnant women, non-pregnant women of childbearing age, infants younger than one year of age, children and adolescents 18 years of age or younger, or children with special health care needs:

(a) population based individual services, such as immunizations, public health education, and screening for health problems;

(b) enabling and non-health support services, such as outreach and referral, that ensure that persons are informed about and referred to other services and programs which they need or for which they may be eligible;

(c) direct health services, including but not limited to public health nursing, home visiting, school health services, nutrition services, health care coordination, preventive and primary care, and other specific health services meeting the specific requirements or needs of the above target groups; and

(d) addressing public health infrastructure needs, including but not limited to assessment of local health problems, health program development, augmentation of service capacity, evaluation and management, and quality assurance.

(3) In order to use MCH block grant funds for services other than the core services listed in (2) above, a contractor must use a formal needs assessment process that includes developing a broad-based and local working group composed of representatives of health professionals, educators, consumers, social services providers, business leaders, and others interested in the health needs of the groups named in (2) above, and with that group, analyzing available statistics and utilizing consensus decision-making to determine the extent to which the objectives are met that are contained in Healthy People 2000 National Health Promotion and Disease Prevention Objectives, published by the U.S. department of health and human services.

(4) In distributing MCH block grant funds, the department will give priority to the counties, regions, and communities with the least resources, the largest proportion of underserved families, and the most serious maternal and child health problems, and will determine who should have priority by utilizing objective health indicators, including, at a minimum, the following:

(a) the number of children in poverty;

(b) the number of women of childbearing age; and

(c) the number of children and adolescents age 18 and under.

(5) The calculations required by (4) above must be based on 1990 census data, updated by projections made by the census and economic information center of the state department of commerce.

(6) The department hereby adopts and incorporates by reference Healthy People 2000 National Health Promotion and Disease Prevention Objectives (DPHHS Publication No. 91-50213), published by the U.S. department of health and human services, September, 1990, and which contains a national strategy for significantly improving the nation's health through the 1990s, and addresses prevention of major chronic illness, injuries, and infectious diseases. A copy of Healthy People 2000 may be obtained from the department's Family Health Bureau, Cogswell Building, P.O. Box 202951, Helena, MT 59620-2951 (phone: 406-444-4743). (History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; Ch. 593, L. 1995; NEW, 1996 MAR p. 2184, Eff. 8/9/96; TRANS, from DHES, 2001 MAR p. 398.)

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